Four Seasons (Emmanuel Christian Care Home) Limited

Park House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We undertook this comprehensive inspection on the 22, 23, 29 July 2015 and the 10 August 2015. Our inspection visit was unannounced.

We last inspected Park House in June 2014 and they were found to compliant.

During this inspection we found breaches of Regulations, 9, 10, 11,12,14,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Park House is a large building located in a quiet residential area of Birkenhead. It is part of the Four Seasons group of health care services. The home is registered to provide accommodation and care for up to 111 people, there were 97 people living at the home at

Summary of findings

the time of this inspection. The building is split into four units. The ground floor (Bidston unit) is for people who do not require nursing care. The middle floor (Central unit) is for people with dementia who may require nursing and the top floor separated into two (Conway units) were for more frail elderly people who may require nursing.

There was a registered manager of the home at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe with staff and this was confirmed by some of their relatives. The registered manager had an understanding of safeguarding; however not all staff spoken with, were clear on the policy and procedures. The manager had responded appropriately to allegations of abuse with the support of the operation and clinical manager, ensuring reporting to the local authority and the CQC as required.

Accidents and incidents were recorded and monitored to ensure that appropriate action was taken to prevent further incidences.

We found concerns with regards to the management of medicines at the home. The administration and record keeping was unsafe. We saw that the provider did not have clear instructions available for staff to give 'as required' (PRN) medicines and prescribed nutrients. Where instructions were available these had not been correctly followed. This placed people at significant risk of harm.

People and their relatives told us the home was short staffed. Staff confirmed this view. We saw that staff were too busy tending to people's personal care needs to interact socially with them or meet all of their assessed needs. This placed people's health, welfare and safety at significant risk.

We looked at records relating to the safety of the premises and its equipment, which were correctly recorded. We spent time conducting a full tour of the home; the basement area was not safe as it was a storage space being used for any mattresses and equipment not being used. This area was also used for offices for activities staff, the cook and the maintenance person. The boiler room was also in the basement area.

The staff recruitment practices were not being followed safely. During this inspection we found that not all relevant checks were taking place.

Staff told us they did feel supported by the registered manager. They said they had not been sufficiently trained as the training was predominantly e-learning. We saw from staff files, that staff had not received appropriate appraisals and supervision. Records for staff training were not up to date and not all staff had not received the Mental Capacity Act 2005 training or understood the reason for its implementation in the home. The manager told us that staff were not fully competent in their roles and understood that the training programme was not up to date. We were informed that the learning programme had not been working effectively.

The provider had not complied with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and its associated codes of practice in the delivery of care. Suitable arrangements were not in place addressed the needs of all of the people living with dementia to ensure their consent to the care they received was appropriately obtained. Staff we spoke with had a limited understanding of what was their role was and their obligations were in order to maintain people's rights.

People's emotional needs were not appropriately assessed nor the support provided, adequately planned or delivered.

People received sufficient quantities of food and drink and had a choice in the meals that they received. Their satisfaction with the menu options provided however, had not been checked. Where people had lost weight this was not always recognised with appropriate action taken to meet their needs. Where people had special dietary requirements, the planning and delivery of care failed to provide sufficient information to ensure people's special nutritional needs were met.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Summary of findings

Staff were observed to be caring, warm and positive in their interactions with people who lived at the home but had little time to chat to people. People's privacy and dignity needs however were not always met in the delivery of care. For example, staff were not available at all times when people were in distress and required immediate assistance.

Care records did not adequately assess people's needs or risks, or plan how to meet their needs. Care records were not up to date and people's care had not been updated when reviewed. For example 'thick and easy', which was a thickener for fluids, to support people with swallowing difficulties, was not being provided appropriately or monitored by staff.

The service was not well led at all times as they did not have effective quality assurance and monitoring systems in place to identify the risks to people's health, welfare and safety and failed to seek people's views on the quality of the service they received. We discussed the issues we had identified at this inspection with the manager and operations manager and expressed our concerns.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 in relation to Regulation 9, Person centred care, Regulation 10, Dignity and respect, Regulation 11, Need for Consent, Regulation 12, Safe care and treatment, Regulation 13, Safeguarding service users from abuse and improper treatment, Regulation 14, Meeting nutritional and hydration needs, Regulation 17, Good governance, Regulation 18, Staffing and Regulation 19, Fit and proper persons employed. You can see what action we have taken at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Inadequate

People were not protected from potential abuse as the provider and their staff had not appropriately monitored people's care. The medication procedures and practices were not sufficient to maintain the safe giving of medicines. The lack of appropriate assessments placed people at risk.

We found the home was short staffed. Staff recruitment was not being monitored effectively and not all relevant checks were taking place.

The medication procedures and practices were not sufficient to maintain the safe giving of medicines. Staff were not following the controlled drugs procedure correctly. Records for PRN medication were not being completed or monitored effectively for individual's pain relief.

The infection control was not being monitored effectively; the kitchen area was particularly dirty with foods being stored inappropriately. There had been no infection control monitoring completed in the home since December 2014.

Is the service effective?
The service was not effective.

Inadequate

Records showed that staff had not received adequate and appropriate training for their job role This meant they may not have the right skills, knowledge and support to do their job effectively. The provider had not complied with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure people received appropriate support and where enabled to participate in and consent to decisions about their care.

The understanding of staff for people's nutritional needs was inadequate and did not ensure where people had special nutritional needs these were met.

Care plans lacked sufficient up to date information about people's health related illnesses, such as weight loss.

Is the service caring?
The service was not always caring.

Inadequate

Staff predominantly caring for the people with dementia had little time to socially interact with them. A lack of social interaction was observed throughout the home.

People's privacy and dignity needs were not always respected. People were not being provided with the care which met their needs.

Is the service responsive?
The service was not always responsive.

Inadequate

Summary of findings

Care records were not always person centred and did not adequately assess or review people's needs or risks. People being admitted did not have the relevant assessments and care plans to ensure they received the correct care and treatment.

Some people did not receive care that met their needs.

The complaints procedure at the home was not always effective. People told us they spoke to staff regarding concerns however they were not always followed up or communicated back to them.

Is the service well-led?

The service was not always well-led.

There were no effective quality assurance systems in place to identify and manage the risks to people's health, safety and welfare. No audits had been conducted in relation to care plans, health and safety, accident/incidents, infection control and staff training.

People's satisfaction with the service had not been sought through the use of satisfaction questionnaires.

Inadequate

Park House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22, 23, 29 July 2015 and 10 August 2015 and was unannounced. The inspection team consisted of four Adult Social Care Inspectors, a specialist advisor for dementia care and an expert by experience for dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

During this inspection we spoke with seven people who lived at the home, thirteen relatives, two visiting professionals, twelve care staff, three nurses, the cook, two activities coordinators, the maintenance person, the manager and the operations manager, the clinical manager and the Local Authority.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at all areas of the home including the communal areas that people shared in the home and with their permission, visited five people's bedrooms. We also looked at a range of records including six care records, medication records, and recruitment records for ten members of staff, training records relating to the staff team, staff rotas, policies and procedures, records relating to health and safety and records relating to the quality checks undertaken by the service.

Inadequate

Is the service safe?

Our findings

All of the people we spoke to said they felt safe. One person said "I feel completely safe here". We spoke with thirteen relatives and they told us that they thought that their relative was safe in the home. All of the visitors told us either they visited the home or that another relative or friend did on a regular basis.

We looked at the risk assessments for six people. The risk assessments in the care plan records looked at were ineffective in some instances. For example one person had an injury on their hand. When we checked the record, we were told that an incident that had occurred between the person and another resident. There were no risk assessments completed in either persons care plans. Another example was that two people were identified as high risk for food and fluid intake. Staff had failed to implement the correct monitoring as required and as such failed to recognise their deterioration in health. The relevant Malnutrition Universal Screening Tool (MUST) scores had also been completed incorrectly by staff. This is a trigger of risk for monitoring people's health.

Another person had psoriasis and was prescribed cream because of the risk of the infection spreading. The risk assessment was not updated and the cream was not being applied as prescribed.

The provider had not ensured that care and treatment was provided in a safe way that met people's individual needs. **These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We looked at the Medication Administration Records (MAR) for 32 people, all had a photograph of the person attached so that staff could identify the person. We found that not all medicines were being administered safely and records informed that some people were not receiving their medicine in accordance with their prescription because staff were not following the instructions.

For example one person had not received their rasurastation from the 19 July up to the 22 July. We asked the nurse on duty why this medication was omitted they said "I don't usually work here and was unaware of the problem". A member of staff told us they were aware of the issue and that the medication had been ordered on the 20 July 2015. Another example was one person being administered co-codamol pain relief, prescribed one a day up to four times daily. The MAR sheet informed that staff were giving two tablets on a regular basis and had not reassessed the individual's pain management. Four people had been prescribed creams or lotions to be applied twice a day. A review of the people's medication care plans showed that there were no records that the people's creams were applied twice a day in accordance with their prescriptions.

We also had some concerns with the recording of and administration of controlled drugs in the home. One individual who had been prescribed methadone did not have the amount required to ensure their pain was manageable. We spent time with the person and we had, at various times throughout the day of the 22 July 2015 to check with staff to ensure they had ordered the methadone medicine. We were concerned because we were present when the methadone was measured into a pot at 10:15. There had been 15ml left in the bottle which was poured into the pot. The prescribed amount was 50 ml at 08:00. A member of staff (who checked the drug after the first person had checked) signed the controlled drug book without knowing what they were signing for. When asked we were told "No I don't know what I have signed for I think it's methadone". The nurse proceeded to leave the medication room and controlled dugs cabinet open when they went to administer the methadone.

The methadone was delivered to the home at 2:40 in the afternoon we were told at 5 pm by the person they had still not had their pain relief. We informed the manager of this and the person eventually got another 35 ml at 5:40 pm. This meant that there was a risk that controlled drugs were mismanaged. This persons medication care plan had also been completed incorrectly by staff in relation to the identification of their medicine demeclocycline. The information recorded was it was a broad spectrum antibiotic which is incorrect as it is for severe salt depletion. The medication care plan for this individual was not up to date and did not reflect that they were on end of life care.

Medicines prescribed as needed are known as PRN medication. There were no relevant care plans in place to monitor people's pain relief. We looked at five people's records that had no information in place or instructions available for staff to inform them when and in what circumstances these medicines were to be given. This meant that people were at risk of not receiving these

medicines safely and that they were not monitored appropriately. Additionally the times of medicines such as pain relief which must have a strict gap between doses, had not been recorded. This meant that the staff giving these medicines could not be sure that a sufficient gap between each dose had been achieved. This placed people at risk of receiving these medicines in an unsafe manner.

We looked at the information in place for three people who had been prescribed 'thick and easy'. This is a prescribed medicine for thickening fluids for people who had been diagnosed as having difficulty in swallowing and were at risk of choking. The information for staff to understand the importance of this medicine was not in their care plans. One person did not have a food and fluid chart and their MAR chart did not inform what amount should be used. One person was given 'thick and easy' by staff who told us they thought the person was on it. There was no information available to inform the correct dosage/ consistency for staff to follow.

Staff, when asked, gave conflicting information as to what amount was to be used for each person in the dining room at lunch time.

There was no effective checking of MAR sheets taking place. Correct and regular auditing would have ensured that the issues identified at this inspection would have been identified and an action plan made so that improvements could be implemented by staff.

The provider had not ensured that care and treatment was provided in a safe way.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us the home was short staffed and staff were always very busy. All thirteen relatives we spent time with told us that the home was short staffed. The relatives told us that at times they felt the home did not have enough staff to care for the people appropriately. They told us they had observed that staff were not always available when needed and that staff rushed around and appeared very busy. Staff told us that they did not have enough staff. They explained that staff absences were not covered at all times and this caused staff to be very busy.

We saw the rotas and the staff ratios for each shift in the four units of the home. There were nine people cared for in bed in the home and all required hourly to two hourly comfort repositioning and checks. There were nineteen people who were immobile and used a wheelchair and required two staff to support them two/four hourly for comfort and toileting. The manager and operational manager told us that they were aware of the staff ratios and at times there were shortages of staff in the units. The CQC had received information from people and whistle-blowers in relation to staffing levels being low. The manager had also informed the CQC when nursing numbers were low and staff had to work longer hours.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the needs of people living in the home. **This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We looked at the personnel records for ten staff including their recruitment records, which also included the records for two new staff. There were omissions in all files. Examples were that in two files there was no photographic evidence of the staff member, that reference letters for three staff had not been validated, and there were gaps in the interview and application records. Two nurses 'Nurses and Midwifery Council' 'pin' numbers (which were evidence that they were competent to practice) were out of date and had they had not had their records updated. There was an issue with one member of staff in relation to their criminal record. The provider had not followed up the information as they should. The applicant was to be employed working with vulnerable people and any area of concern, should have been risk assessed. We discussed the monitoring of staff recruitment records with the registered manager who said she had not audited the recruitment records in a while.

The provider had not ensured that safe systems of recruitment procedures were being operated effectively. **These examples are breaches of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We looked at the cleanliness of the home and saw that the communal areas of the home appeared clean and tidy. The medication rooms were seen to be clean and clutter free.

Inadequate

Is the service safe?

We saw that there was a cleaning schedule for all areas of the home. There were bad odours in areas of the home including two people's bedrooms and two communal lounges. We discussed this with the registered manager who told us that the smell came from the carpets. By 29 July 2015 the carpets had been removed in the two bedrooms and we were told the lounge carpets would be changed imminently by the operations manager. We spent time in the kitchen which was not clean. The cook was wearing dirty overalls. The floors and cupboards were visibly dirty. The serving trolleys had encrusted old food dried on them but we were told that they had been cleaned and were ready for use. The storage of food was very poor. The storage room was very dusty and the food containers were dirty and not sealed. Fridges and freezers were not clean. The service had received a 3 out of 5 rating for Food Hygiene from environmental health in January 2015. The manager and the regional manager viewed the kitchen on the 23 July 2015 and instigated a deep clean of it. We checked the kitchen again, the third day of the inspection and we observed it to be clean with all foods being stored appropriately.

We observed that the refuse bins at the home were overflowing where they were situated, in the car park and outside peoples rooms. Food was strewn on the ground and animals and birds were feeding from it. The manager and operations manager told us that they had an issue with the contractor and had requested more bins. This issue was evident on the 22 when we first discussed it with the managers and 23 July 2015. On the 29 August 2015 there were more bins and the food spillages had been cleaned. We liaised with the local authority environmental health team in relation to our findings, so they would be aware of the problem.

We asked about cleaning audits and were told that there were infection control champions on all four units who would report to the manager. We requested an infection control audit from the manager; they told us they did not have any audit completed to show how they were monitoring the infection control.

The provider had not ensured that care and treatment was provided in a safe way for people living in the home. **These examples are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We spent time in all areas of the premises and could see that Park House was mainly well maintained and comfortable for the people living there. Health and safety had been checked through various risk assessments and audits. The manager was responsible for checking the environment and there was a designated maintenance person. We saw records of checks that had taken place daily, weekly and monthly. Contracts were in place for the maintenance and servicing of gas and electrical installations and fire equipment. We saw records to show that regular health and safety checks were carried out and that regular servicing and checks were also carried out on equipment. A fire risk assessment was in place and had been reviewed and updated in December 2014.

We spent time in the basement area where there were rooms being used for archiving records, storage and where the water tanks were. One room was full to the top with materials and boxes of lots of books and other items, including games. We were told this was the room for the two activity coordinators and the cook who did their paper work in there. The room was not conducive to people spending time in it; it was poorly lit and had no ventilation. Outside the rooms were a lot of used mattresses and other equipment which made fire evacuation access difficult. We were told this was a 'dumping ground' for staff if they had nowhere else to put things. We informed the manager straight away as this could be a potential health and safety risk.

There were four units in the home. All had their own keypad to enter and exit the unit. Each had a password number to operate each keypad.

There was a safeguarding procedure in place for notifying the local authority and the CQC when an incident had occurred at the home. The registered manager did liaise with the CQC when required and would send any relevant records. Not all with the staff we talked with were aware of the policy and procedure and understanding of the arrangements for safeguarding vulnerable adults. However, staff told us that if they had any concerns about any allegations of abuse or neglect they would report this to the manager or senior staff.

Inadequate

Is the service effective?

Our findings

We spent time talking with six people who lived in the home. Comments we received included "It's fine here" and "The staff are good, really busy people". Five of the relatives we spoke with told us that they were happy with the care that their relative received including "My wife has settled in well here, safe an staff are brilliant" and "Staff have a hard job to do but always polite to my relative and me". All of the eight other relatives told us the staff were very busy and were always rushing around. Comments included "My relative is not receiving the care she once was, no bath for nine months" and "My relative has had severe hearing difficulties that have not been looked at appropriately. We as a family have requested medical attention for a while".

We asked the staff if they felt supported in their roles. They told us that they were not adequately supported by the manager and said that they did not feel supported. We looked at supervision records for ten staff, two of whom had recently been employed. We saw that supervision was being provided at different timescales from every twelve weeks through to no supervision at all. Staff annual appraisals were not up to date; staff told us that they had not had an annual appraisal. The registered manager told us that supervision and appraisal meetings were not up to date and this was something she needed to action. We were told that some of the responsibility was with the nurses who were the seniors in all four units. Part of their role to was to supervise staff.

We asked the registered manager about staff training and requested they provide us with a training matrix; we were not provided with a training log of completed training. We looked at the personnel records of staff which showed that some of the training they had completed included moving and handling, safeguarding, communication, food hygiene, nutrition, MCA and DoLS and dementia care, fire safety, first aid and medication training. However, the record showed that not all staff had completed MCA and DoLS training, nutrition awareness training or eating and drinking difficulties training. Staff told us that the majority of their training was e-learning and most told us they were not up to date. A new person who had been working at the home for two months had not had any induction training and only had been provided with access to the e-learning the week before. The registered manager could not tell us where all staff were at, in their training and development

We looked at how staff were assessed as being skilled and competent to undertake their job role. We saw that there were no arrangements to show how learning was monitored. We identified at the inspection, gaps in staff's knowledge and understanding, especially with regards to mental health. Staff did not have a clear understanding about capacity, decision making and best interest decisions. The registered manager informed us that not all staff were not competent in their roles in relation to these areas.

The provider had not ensured that staff received appropriate training to enable them to carry out the duties they were employed to perform. **These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive options are taken.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the manager and staff. The manager and a lead nurse on the Conway unit demonstrated an understanding of what was required. However, all the other staff spoken with were not clear on what it meant to implement a DoLS authorisation or about the best manner to support people with fluctuating capacity.

The lead nurse on Conway unit had completed and submitted DoLS applications for eight of the nine people on the unit for people living with dementia. At the time of the inspection they had received one authorisation that required monitoring and actions by staff. One person had not been referred and we were informed about the rationale of this; we did reiterate the MCA and the recent judicial requirement to the lead nurse. According to the ruling, the ninth person should also have been referred.

We looked at the eight applications that had been submitted for people living with dementia on Conway unit. We reviewed two care records on Conway unit and spent

time talking with staff who were aware of the DoLS applications for the eight people. We were also informed by the manager and staff that applications for a deprivation of liberty order was needed for other people living in the home. We were told that there were fourteen people living on the Central unit whose care included bed and chair sensors and locked doors. Staff had not applied for a DoLS for them. The registered manager said this was because the local authority had requested they prioritise and the manager had not referred. We discussed the responsibilities of the home in relation to the MCA and DoLS which required that all applications should be made in a timely manner as required.

The provider has not protected service users from improper treatment as the correct procedure was not being followed for all service users who were deprived of their liberty. **These are breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We reviewed six people's care files including the two on Conway unit. We saw that were people were noted as living with dementia or having fluctuating capacity, there was no evidence that the provider had followed the required legal processes for four people. This would have ensured people had given appropriate consent or participated in decisions in relation to their care.

We looked specifically at care files regarding consent and how the provider was assessing the capacity of people. Each section called for a signature, but there was no signature in place. In one file the consent for photos was initiated by a relative; the person's ability to consent to their photograph usage had not been determined. Families cannot give consent to the care and treatment of a relative without statutory authority to do so. We discussed with the manager and staff if they were aware of which relatives had a legal authority to act on behalf of people. They informed us that they were unaware of this. We looked at people's care records and could find no information that showed if relatives had been granted the legal authority to act on behalf of their relatives or the extent of that authority. There was no policy available that would guide and support staff in making sure that people's individual rights were supported.

We reviewed records regarding DNAR (do not resuscitate). We saw that where this was in place, they had not been reviewed in order to determine if they remained appropriate. Additionally where the person lacked capacity to make this decision an assessment of their capacity and a meeting to discuss their best interests had not been held. Without undertaking the proper legal process people were at risk of not having their wishes or rights upheld.

In order to support the appropriate consent for the management of medication we looked at the policy to see if there was any arrangements should it be needed for the giving of medicines without the persons permission known as "covert" administration. The policy contained guidance and information regarding this. We saw that on Conway unit a capacity assessment had been undertaken with a best interest decision including the person, their family, their GP and a pharmacist. The information recorded informed that the assessment had been competently considered.

We were provided with an organisational policy on the MCA that was not up to date and which was dated 2013.

The provider had not ensured that all people had been appropriately assessed for capacity as care and treatment of people must only be provided with the consent of the relevant person. **These are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We spent time on the first day of this inspection conducting a SOFI (this is a formal observation of people and how staff interact with them) in the dining room on Bidston unit at lunchtime. Staff were seen to support three people who could not manage themselves. Staff did talk to the people they were supporting and did so in a respectful way; the staff did not rush the people so that they maintained their dignity. The interaction was seen as positive, however staff were busy and intermittently left the people as they had to also deliver meals to six people's rooms.

We were told that people had a choice to either eat their meals in the units' dining rooms or their bedrooms. The home operated on set mealtimes during the day and had a four week rolling menu from which people had options to choose from. People had varied opinions about the amount and type of food they were offered but we saw little evidence that people's feedback on the menu options provided were gained to ensure they were happy with the choices.

The main meal was served at lunchtime. The menu of the day was on tables in the dining rooms. However the writing

could not be easily read by the inspectors. The expert by experience ate lunch with the people in Bidston unit. There were no picture menus available or menus available in suitable formats to meet people's individual needs. We discussed specialist diets with the cook who told us that there were a number of people who needed soft or diabetic diets. He said fortified diets were blended on the relevant units by staff. We asked about low fat diets and were told "We just give them half the amount". He was not aware of anyone being on a high protein diet.

We looked at care plans and nutritional information which identified people's food and drink preferences and specific dietary requirements. When we reviewed nutritional care plans for eight people we saw that two people required a fortified diet, one person was on a high protein diet and six people were on 'thick and easy' which was a powdered supplement for people with swallowing difficulties.

We looked at how people who needed a special diet or were at risk of poor nutrition were monitored to make sure that they received this diet. We saw that where there were food and drinks records available these were not all fully completed nor did they clearly outline how much of the food the person had eaten. As an example the records would state "A small amount eaten" but there was no description as to how much food this was. Fluid monitoring was also not being completed appropriately. One person was on reduced fluids however there was no monitoring record in place, to be completed by staff.

Tea and coffee was served mid-morning and afternoon on all four units by care staff.

We reviewed the care plans of eight people who were identified as having a special dietary requirement in relation to a medical condition. We found a lack of any appropriate nutritional planning and information in relation to the people's dietary requirements and risks. We saw three incorrect calculations of a MUST scores (a risk assessment to determine if a person is at risk of malnutrition) where staff failed to recognise or take action with the person's weight monitoring and weight loss. The monitoring of their food/diet and fluid was inconsistent. Additionally the people were prescribed a nutritional supplement to be given three times a day. Neither the person's diet sheets nor their MAR records recorded that they had received this supplement daily. The risks to peoples' nutritional needs had not been recognised nor appropriate action taken.

The provider had not ensured that the nutritional and hydration needs of people was consistently met, or monitored that their needs. **This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We reviewed the premises during our visit. The service was decorated in a dementia friendly manner with colour coded toilets and bathroom doors for people to identify them. The activity coordinators had done collages and put stimulating pictures on walls throughout the home. Bedrooms we visited were personalised, spacious and clean.

Inadequate

Is the service caring?

Our findings

We asked the people living in the home if the staff were caring. Most people responded positively about the staff. People's comments included, "The staff are nice" and "Staff are good". Visitors told us, "The staff are fantastic, they care, however always running around as they are short staffed" and "My relative has lived here a long time and has not had the treatment required for her hearing. Her appearance is good when we visit" and "My mother has not received the care she used to as they have not bathed her in nine months. We as a family were told it's because of her weight". They do look after my relative well". Another commented "There are some brilliant staff here, just not enough of them".

We observed the staff talking with and supporting the people who lived in the home. The staff were mainly caring in their approach and appeared to have warm, positive relationships with the people that they were supporting. There were different staffing levels on the four units, in the small unit Conway, there were a lot of staff interactions and staff had the time to spend with people. This was not the case on the other three units, where we observed staff to be constantly dealing with people's care need requirements with little or no time to socially interact with them. At times on units there were no staff available, we were told this was because staff were supporting people who needed two staff to support them, as required in the care plans of individuals. Some people needed staff to support them hourly or two hourly with comfort checks, toileting and other care and treatment requirements. We asked for the numbers of people cared for in bed and were told there were currently nine people in bed and 20 people who were not mobile and who required two care staff for support at all times.

One person who had been admitted into Park House on the 18 July 2015 was not being provided with the care and support required. We looked at their care records which did not fully inform us what care they should be receiving. They were admitted for end of life care. The person was walking down the corridor requiring assistance from staff who were present in the corridor but who did not provide it. We at numerous times of the day had to request care, treatment and support be provided to this individual as they approached the team. We had noted that the alarm buzzer which was in this persons room, was broken. This had been mentioned to staff early in the day

In the mid-afternoon, a member of the CQC inspection team saw that the person was falling out of bed, being nearly on the floor. They assisted and used the buzzer to no avail. The inspector assisting the person had to shout for help for nearly a minute. Another member of the CQC team managed to summon Park House staff who then supported him back into bed. We found that the room buzzer had not been repaired or changed, even though we had mentioned it to staff some several hours earlier.

We spent time throughout the four day inspection monitoring the care of this person, all managerial staff got involved in their care and a lot of meetings took place to ensure he was supported and provided with the care and treatment he should have received when he moved into the home.

Another person was heard by the team screaming very loudly, when investigated they were on the floor below. We observed staff walking past and not doing anything to check or support the individual. Other people were clearly distressed by the shouting and screaming. We were told that "They always do this, shout out". A member of the inspection team requested the manager to accompany them to the person's room. The manager went in to speak to the lady who stopped shouting immediately and was comforted by the attention. We were told the shouting was a sign of pain or constipation. We looked at the care records which stated that the person had been cared for in bed for a period of time and was waiting for delivery of a chair she had been assessed by the occupational therapist, as requiring. We looked at the pain management record which were not very clear. Monitoring records were not completed as required in the care plan which required that there should have been two hourly checks.

We spoke to family members of a person who had lived at the home for a long time. The person had been moved to another unit due to an incident with another person. The family told us that their relative had not been bathed for nine months as staff told them they were too heavy. We looked at the records for this person and it was confirmed

Inadequate

Is the service caring?

they had not had a bath. We discussed the issue with the manager and operational manager as the family had spoken to staff but no one had responded to their questions.

Another lady had problems with their ears and the family told us they had requested medical intervention numerous times. This person had suffered for years with an ear problem that was not dealt with effectively by staff. Staff were putting ear drops in but they had no effect on the persons ear problem. We bought this to the attention of the manager and operations manager. On the last day of this inspection the person was attending an appointment at their GP to have treatment.

We did see that when staff did have time to interact with the people they did use the time appropriately. We saw one member of staff dancing with a person who was thoroughly enjoying themselves, another member of staff was heard to sing and people joined in. We spent time on all four floors intermittently over the four days of inspection. We saw a lot of people walking the corridors aimlessly doing nothing. Each person was spoken with, comments made included "I have nothing to do" another "I like to walk. It is better than sitting in my room". A lot of the people were unable to communicate how they were feeling as they had dementia, however when spoken with most were happy to talk to us.

We did see staff throughout the inspection attending to the requests of people in a dignified way. However due to the staffing levels not being appropriate when people requested help with going to the toilet or required support staff they were unable to act straight away. Numerous times throughout the inspection the inspection team had to find staff to support people as they were not around. This included a person who had been in the corridor who defecated there, another person shouting out for help, another person falling out of bed. We saw that people were not provided with the care and treatment they had been assessed to receive. We noted that this caused distress and was undignified.

The provider had not ensured that the people living at Park House were treated with dignity and respect. **This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Inadequate

Is the service responsive?

Our findings

We asked the people who lived in the home if they did any activities. They told us that there were activities provided. One person said "We have things happening here, I like bingo" another said, "I go to the poetry". Visitors we spoke with told us that there were not aware of many activities being provided. One visitor said" There should be more activities for people with dementia, people just walk around".

We spent time talking to the two activities coordinators who both worked 28 hours a week. They had a programme, however we were told this would change if people wanted to do something else. The activity coordinators had worked at the home for over a year and neither had been provided with any training or supported by having any supervisions or appraisals. The activities coordinators did not have any training in providing activities to people living with dementia. We were told there was a budget of £80.00 a month for activities and the activities coordinators had to raise additional funds by holding charity events.

Most people living in the home spent most of their time in the lounge areas during the day but were sitting most of the time in silence with the television on in the background. There were staff intermittently in the lounges; we spent time, at different times of the day, in all four units in the home over the four day inspection. People were seen to be lacking in stimulus, walking around aimlessly or sitting in chairs with little interaction from staff. The activity coordinators were seen to provide activities such as bingo to six people one day and poetry reading another day to seven people. We observed them interacting with people by talking to them and we saw them visiting three people in their rooms. Other than this we observed that there was insufficient stimulation or specialist equipment to enhance the majority of people's lives or to assist them in maximising their potential for independence or enjoyment. There were no activity care plans for any of the 97 people living at the home and the activity plan was only available as a hand written sheet.

We asked about how people were supported with their personal care and we were told by staff that they asked people daily about having a bath. Staff told us that people in the home could have a bath whenever they requested one or when it was required in their care plan. A person had not had a bath for nine months and staff had not actioned any plan to ensure a bath would be available to the individual, this did not reflect the persons individual needs and did not provide a person centred care plan.

We looked in detail at six care plan records for people living in the home and we had concerns about three of them. The care and treatment was not designed to meet all their needs. Care plans were not person centred and were not updated to reflect changes. Care records did not reflect the care actually being provided by staff in some instances or reflect people's current needs.

The care plans available had not incorporated people's personal preferences or choices, although in some cases these were available elsewhere within the file. Care plans centred on meeting peoples physical needs and made little or no reference to their emotional or psychological needs. As an example we saw that one person could become very distressed during the day and could shout a lot. There was no information in the care plan as to why this might happen or how to help this person. The situation was not monitored in order to make sure that any changes in their needs were recognised.

We saw that where people's needs changed, such as them developing an infection, as an example, this information was not included in their care planning and did not provide up to date instructions to staff as to how to meet the person's individual needs.

One person had moved into the home on end of life care and the information in place in their care plan was inadequate and clearly did not meet their needs. This person had complex medical needs that were not being monitored and the lack of appropriate person centred care plan placed them at risk of harm.

We were unable to see what arrangements were in place in order to monitor and give medicines that were prescribed as needed. As an example, several people required pain relief as needed. We were informed that a pain chart had been introduced to monitor people's pain but this was not available in the person's care records, bedroom or within the daily records.

The care and treatment for people was not appropriate and did not met their needs or reflect people's individual preferences. **This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Inadequate

Is the service responsive?

Observation records were not being recorded appropriately, this included comfort, nutrition and continence care. Care plans indicated that monitoring and observations should be implemented by staff however they were not happening. The manager told us that the observation and monitoring records required improvement and staff had received training but more training was required for them to be competent to do this effectively.

People we spoke with told us they would speak to the registered manager or staff if they were unhappy about anything and they wanted to make a complaint. Relatives we spoke with told us they had made complaints in the past that had not been dealt with by the manager or the provider effectively, as the issues were still occurring. These issues included implementing a diet for one person and the family being informed and involved. Another complaint was a person had ongoing issues with their ears and the family had raised concerns. They had also raised the concern about the odour in their relative's room. The registered manager when asked, said that she was not sure why they had not responded to the complaints. We requested the complaints records from the manager who confirmed that there were no records of historic complaints in the folder. We discussed the issues with the operations manager who initiated actions straight away for all concerns raised. We were later told that meetings had taken place and that the records recorded that all issues were dealt with appropriately.

We looked at the seven recent complaints records that were in the folder. All had actions completed and relevant professionals had been liaised with.

There was a statement by the front door regarding how to make a complaint, people we spoke with told us they would talk to staff if they had a complaint. Visitors told us they would talk to the manager if unhappy about anything.

Inadequate

Is the service well-led?

Our findings

We spent time talking with the people living at the home, relatives and staff about the manager and the provider. People told us that the registered manager was approachable. Comments included "The manager is approachable enough, however we have had difficulties when trying to meet with her" and "Don't really know who the manager is, I speak to the nurse" another commented "I'm not sure who the manager is, they are always changing".

Staff we spoke with about the registered manager and the support they had, all commented on the lack of staffing on all units and told us they had discussed with the manager. We were told the registered manager was a nice person but did not always listen or act on information. An example was that nursing staff were late administering medication when numbers were short on units as they had to provide other support to people and were unable to concentrate on medication.

We checked what systems the provider had in place to manage the health, welfare and safety risks posed to people who lived at the home. We found a lack of adequate systems. The systems that were in place were not effective and their operation by the provider was not well managed. For example, we saw that no meaningful audits had been completed. Medication audits lacked information and clarity with no actions implemented when issues were found.

Care plan audits had been completed on some of the care plans we saw. We looked at six people's care records and found inconsistencies in three and issues in all care plans. The audits did not reflect this and as a result the audits were ineffective. The registered manager told us that the nurse managers on the four units were responsible for ensuring care plans were up to date and relevant to meet the individual's care and treatment needs effectively. No actions or findings were drawn from the audits.

The registered manager told us that accident and incident audits had been undertaken. However, we were not provided with the last audit as the manager did not provide it when requested. We looked at the reported incidents' records in a file. There was no information informing how the provider monitored trends in the types, location and/or times of accident/incidents in order to learn from how accident and incident occurred so that they could be prevented.

There were no up to date audits in place for infection control and environment, staff training and development, staff recruitment or medication. Regular audits would have identified the issues we identified during our inspection so corrective action could have been taken.

We spent time talking with the registered manager regarding the lack of infection control audits specifically around the kitchen because action was required immediately. The Environmental Health team visited the home in January 2015 and awarded the home a three out of five rating. This was because the home was not meeting their food hygiene procedures. There were no plans in place as to how the service could improve in this area or any determination as to any potential risks in a reduction of three stars in their food hygiene rating. We reported our findings to the local authority environmental health team. The registered manager reported the findings to the operations manager visited the kitchen and as a result, implemented a deep clean of all areas of the kitchen and storage. On day three of this inspection we visited the kitchen again and it was seen to be acceptable.

The provider had a lack of effective quality management systems in place at the home. We found that the provider failed to show any accountability or responsibility for the lack of effective systems in place. This showed us the home was not well led or well managed in the delivery of care by the provider. We spent time with the clinical manager who informed us that the provider was implementing new systems that were 'live'. An example was that an IPad was to be used for all quality checks and information would be shared for all levels of staff. We were shown the new system and were told realistically that any audits would not be evident for at least three months.

We saw no evidence that people who lived at the home and/or their relatives or staff had been asked for their feedback on the care provided by the home since 2014. This meant the provider did not have a system in place to enable people's views to be sought so that they could come to an informed view of the quality of the service provided so that improvements could be made and any

Inadequate

Is the service well-led?

suggestions acted upon. We were told by the registered manager that this has not been initiated as yet. We later found that the provider had implemented the new IPad system for gaining feedback on the 27 July 2015.

We looked at the policies and procedures available in the service to guide and support staff. We found that these were out of date, and was informed that they were all under review. We asked the manager for copies of the latest guidance from NICE (National Institute for Clinical Excellence) for medication management and the codes of practice for the mental capacity act. The manager confirmed that these were not available. Without having up to date guidance the service was unable to reflect and action on best practice.

The provider had no effective arrangements to assess, monitor and improve the quality and safety of the services provided. **These are breaches of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.**

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: The provider had not ensured that the people living at Park House were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider had not ensured that all people had been appropriately assessed for capacity as care and treatment of people must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider has not protected service users from improper treatment as the correct procedure was not being followed for all service users who were deprived of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the needs of people living in the home.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider had not ensured that safe systems of recruitment procedures were being operated effectively.**